



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

NERVE CONDUCTION EVALUATION

Respondent Name

ACE AMERICAN INSURANCE COMPANY

MFDR Tracking Number

M4-10-4104-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

May 11, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "TX Worker's Compensation Law does not require preauthorization for our procedures"

Amount in Dispute: \$5,180.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Coventry's Provider Bill Review department has reconsidered the above mentioned dates of service and have determined that the most recent review was accurate."

Response Submitted by: Coventry Healthcare, Workers' Comp Services, 5130 Eisenhower Boulevard, Suite 150, Tampa, Florida 33634-6348

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 28, 2009	Evaluation and interpretation of results from nerve testing and diagnostic ultrasound.	\$5,180.00	\$596.79

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out rules for prospective and concurrent review of health care.
3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 197 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT.
 - (880-155) – DENIED PER INSURANCE: NO PROOF OF PRE-AUTHORIZATION PROVIDED 100%
 - 39 – SERVICES DENIED AT THE TIME AUTHORIZATION/PRE-CERTIFICATION WAS REQUESTED.
 - (880-122) – DENIED PER INSURANCE: PRE-AUTHORIZATION REQUEST WAS DENIED (RULE 133.6000) 100%
 - (880-192) – PAYMENT DENIED: TREATMENT IS NOT AUTHORIZED ON THIS CLAIM. 100%

Issues

1. Under what authority is the request for medical fee dispute resolution considered?
2. Did the respondent's position statement raise new denial reasons or defenses?
3. Did the respondent support the insurance carrier's reasons for denial of payment?
4. What is the recommended payment amount for the services in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. The requestor is a health care provider that rendered disputed services in the states of California and Florida to an injured employee with an existing Texas Workers' Compensation claim. The health care provider has requested medical fee dispute resolution under 28 Texas Administrative Code §133.307. Because the requestor has sought the administrative remedy outlined in 28 Texas Administrative Code §133.307 for resolution of the matter of the request for additional payment, the Division concludes that it has jurisdiction to decide the issues in this dispute pursuant to the Texas Workers' Compensation Act and applicable rules.
2. The respondent's position statement raises new denial reasons or defenses that were not listed among the claim adjustment reason codes presented on the submitted explanations of benefits. 28 Texas Administrative Code §133.307(d)(2)(B), effective May 25, 2008, 33 *Texas Register* 3954, states that "The response shall address only those denial reasons presented to the requestor prior to the date the request for MDR was filed with the Division and the other party. Any new denial reasons or defenses raised shall not be considered in the review." No documentation was found to support that the respondent presented these denial reasons to the requestor prior to the date that the request for medical dispute resolution was filed with the Division; therefore, the Division concludes that the respondent has waived the right to raise such additional denial reasons or defenses. Any newly raised denial reasons or defenses shall not be considered in this review.
3. The respondent denied disputed services with claim adjustment reason codes 197 – "PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT."; (880-155) – "DENIED PER INSURANCE: NO PROOF OF PRE-AUTHORIZATION PROVIDED 100%"; 39 – "SERVICES DENIED AT THE TIME AUTHORIZATION/PRE-CERTIFICATION WAS REQUESTED."; (880-122) – "DENIED PER INSURANCE: PRE-AUTHORIZATION REQUEST WAS DENIED (RULE 133.6000) 100%"; and (880-192) – "PAYMENT DENIED: TREATMENT IS NOT AUTHORIZED ON THIS CLAIM. 100%." The Division notes that Rule 133.6000 (cited above by the insurance carrier) does not exist. 28 Texas Administrative Code §134.600(c)(1)(B) provides, in pertinent part, that the carrier is liable for all reasonable and necessary medical costs relating to the non-emergency health care listed in subsection (p) only when "preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care." Review of the submitted information finds that the disputed services are diagnostic services not listed in §134.600(p). No documentation was found to support the insurance carrier's denial reasons. Reimbursement will therefore be considered per applicable Division rules and fee guidelines.
4. This dispute relates to professional medical services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.203(c), which requires that "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83 . . . (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year." The applicable Division conversion factor for calendar year 2009 is \$53.68. All services were billed with modifier -26, indicating that only the professional component (the evaluation and interpretation of reported data) was performed. Reimbursement is calculated as follows:
 - Procedure code 76604-26, service date October 28, 2009, performed in Los Angeles County, California, has a Medicare payment rate of \$30.07. This amount divided by the Medicare conversion factor of 36.0666 is 0.833735367. This amount multiplied by the Division's 2009 conversion factor of \$53.68 results in a MAR of \$44.75. This amount is recommended.
 - Procedure code 76856-26-51-59, service date October 28, 2009, performed in Los Angeles County, California, has a Medicare payment rate of \$37.82. This amount divided by the Medicare conversion factor of 36.0666 is 1.048615617. This amount multiplied by the Division's 2009 conversion factor of \$53.68 results in a MAR of \$56.29. This amount multiplied by 3 units is \$168.87. This amount is recommended.
 - Procedure code 95903-26, service date October 28, 2009, performed in Palm Beach County, Florida, has a Medicare payment rate of \$30.28. This amount divided by the Medicare conversion factor of 36.0666 is 0.839557929. This amount multiplied by the Division's 2009 conversion factor of \$53.68 results in a MAR of \$45.07. This amount multiplied by 4 units is \$180.28. This amount is recommended.

- Procedure code 95904-26, service date October 28, 2009, performed in Palm Beach County, Florida, has a Medicare payment rate of \$17.57. This amount divided by the Medicare conversion factor of 36.0666 is 0.48715432. This amount multiplied by the Division's 2009 conversion factor of \$53.68 results in a MAR of \$26.15. This amount multiplied by 4 units is \$104.60. This amount is recommended.
 - Procedure code 95925-26-51-59, service date October 28, 2009, denotes services defined as "Short-latency somatosensory evoked potential study, stimulation of any/all peripheral nerves or skin sites, recording from the central nervous system; in upper limbs." Review of the submitted information finds that the medical documentation does not support this service as billed. Reimbursement is not recommended.
 - Procedure code 95926-26, service date October 28, 2009, performed in Palm Beach County, Florida, has a Medicare payment rate of \$27.44. This amount divided by the Medicare conversion factor of 36.0666 is 0.760814715. This amount multiplied by the Division's 2009 conversion factor of \$53.68 results in a MAR of \$40.84. Although the health care provider billed this service with 2 units, per Medicare payment policy, this procedure code has a bilateral surgery payment policy indicator of 2, which indicates that the 150% payment adjustment does not apply; if the procedure is reported twice on the same day (or with a 2 in the units field), the payment is based on the lower of the total actual charge for both sides or 100% of the fee schedule for a single service. The lower amount is \$40.84. This amount is recommended.
 - Procedure code 95934-26-50, service date October 28, 2009, performed in Palm Beach County, Florida, has a Medicare payment rate of \$25.73. This amount divided by the Medicare conversion factor of 36.0666 is 0.713402428. This amount multiplied by the Division's 2009 conversion factor of \$53.68 results in a MAR of \$38.30. The health care provider billed this service with modifier -50, indicating a bilateral procedure. Per Medicare payment policy, this procedure code has a bilateral surgery payment policy indicator of 1, which indicates that the 150% payment adjustment policy applies; reimbursement for a bilateral procedure is based on 150% of the fee schedule amount for a single code. 150% of \$38.30 is \$57.45. This amount is recommended.
5. The total recommended payment for the services in dispute is \$596.79. This amount less the amount previously paid by the insurance carrier of \$0.00 leaves an amount due to the requestor of \$596.79. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$596.79.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$596.79 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

<div data-bbox="134 1522 235 1549" data-label="Text">Signature</div>	<div data-bbox="592 1484 971 1549" data-label="Text"> Grayson Richardson Medical Fee Dispute Resolution Officer </div>	<div data-bbox="1104 1484 1429 1549" data-label="Text"> November 24, 2014 Date </div>
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.